Editorials

The Coming of Age of Performing Arts Medicine

IN 1989 A REVIEW APPEARED in *The New England Journal of Medicine* describing the medical problems that occur in performing musicians.[1] In providing an editorial comment to that review, I suggested that this relatively new field of medicine might be coming of age.[2] In this issue of *The Western Journal of Medicine*, Ostwald and colleagues provide a comprehensive survey of the broader field of performing arts medicine.[3] The abundant information that they have eloquently summarized does indeed support the idea that performing arts medicine has reached maturity.

Certainly the field has continued to grow as more physicians and other health care professionals are expressing interest in performing arts medicine. A professional organization, the Performing Arts Medicine Association, was established by a group of physicians in 1989, and its membership is steadily expanding, now including nonphysicians as well. New performing arts medicine clinics and groups have been organized in various cities, both in the United States and abroad, many encompassing the many disciplines called for by Ostwald and co-workers. In some countries, including the United Kingdom, there have been requests for national initiatives to tackle the important issues regarding health care for performing artists.[4] A textbook of performing arts medicine has appeared,[5] and another, to be published in German, is currently in preparation. The journal, *Medical Problems of Performing Artists*, has thrived as a repository of information relevant to the field, as is evidenced by the number of references to that journal in the article by Ostwald and associates. Another publication with a somewhat different focus and slant, the *International Arts Medicine Journal*, has more recently appeared on the scene.

Meetings and symposia on various aspects of performing arts medicine—sponsored by health care institutions, schools, and performing arts groups—are bringing the concept of arts medicine to a much wider audience. Several professional medical societies have formed special interest groups or sections in performing arts medicine, and seminars or workshops on various topics can be found on the agenda at national meetings of these associations.

Despite all of this, we cannot be satisfied with our progress. Many—perhaps even most—physicians and other health care professionals are completely unaware of these developments. An equally substantial number of performers, including dancers, musicians, and especially those in theatrical arts, remain ignorant of the increased and specialized interest in their health problems. Many of those cognizant of the existence of these services are unable to take advantage of them because of inaccessibility. Performing arts schools and organizations, including dance companies and orchestras, even if aware of the increased attention being paid to the medical care of performers, often remain unreceptive or indifferent to dialogue and interaction. In some cases it is unclear whether this represents inertia, the fear of promoting the development (or simply the admission) of problems, or active disinterest and antagonism. A large number of performers, especially students, young professionals, freelancers, and members of small ensembles, are unable to obtain specialized services, either because of their location or because of financial limitations. Even for members of orchestras or companies with comprehensive health care plans, the limited number of arts medicine practitioners may not be on the list of acceptable providers.

There is little evidence that the development of performing arts medicine has had any effect on methods of teaching, on the playing, practicing, or dancing habits of performing artists, or on the incidence of performance-related problems. In my own practice, I see indications of this repeatedly. Over the past 14 years there has been no decrease among my patients in the duration of symptoms from onset to the initial medical consultation (the mean is still 30 months), suggesting that seeking professional advice from physicians, or indeed other health care providers, remains relatively low on the list of options considered by performers.

Performing arts medicine has much work to accomplish. An enormous number of questions remain unanswered regarding the mechanisms, contributing factors, and methods of management of even the most common disorders. There is even little agreement on the diagnostic terms used to describe these problems. For instance, the trunk and arm pain so commonly experienced by instrumentalists may be characterized as overuse, tendinitis, cumulative trauma disorder, repetitive motion disorder, occupational cervicobrachial disorder, or regional pain syndrome. The pain may be attributed to inflammation, strain, or sprain; a clinician may localize the disorder to tendon, muscle, nerve, or connective tissues. Regarding the mechanism, some would focus on ergonomics, considering the static and dynamic loads associated with a particular activity. Is the problem one of excessive playing, faulty technique, or both? Is it caused only by stress? Or is it entirely attributable to hysteria or even feigned?

Performing artists are understandably bewildered by the array of practitioners offering advice and help. Does a performer see a teacher, coach, physical therapist, massage therapist, Alexander or Feldenkrais instructor, psychologist, or physician? The treatment suggested may include relative rest or total abstinence, exercise, the modification of posture, medications, massage, manipulation, change in diet, technical alterations, relaxation technique, stress management, injections, or even surgical therapy. Any of these at some time may be useful and even necessary, but the potential for confusion and conflict is obvious, especially when one of these approaches is touted as "the only way."

Where does performing arts medicine go from here? I could not agree more with the suggestion of Ostwald and colleagues that a multidisciplinary and collaborative approach to the problems of performing artists is not only desirable but absolutely necessary. Education must be the most important focus of attention for physicians in performing arts medicine. Physicians need to educate themselves and their colleagues regarding the progress that has been made and what is currently available. They need to learn more about the mechanics involved in the various types of performance in which patients are involved. Even more, physicians need to understand what drives and motivates performers and performing arts students.

It has been popular to compare performing arts medicine with sports medicine and to assume that skill in one field automatically applies to the other. Although there are obviously similarities both in the types of disorders seen and in the methods of treatment, there are a number of differences as well. Performing artists are not athletes, and to approach them with the same mind set is to court disaster. Most physicians practicing performing arts medicine have developed whatever skills they may have by seeing a large number of performer-patients, by discussing issues with colleagues in various disciplines, medical and musical, and to some extent by trial-and-error approaches to treatment. A sufficient body of knowledge has now accumulated to begin developing training programs for interested physicians. There are many problems to surmount. It seems feasible at this point to offer elective time during or after formal residencies or fellowships in selected recognized specialties, but ultimately a program that provides exposure to several relevant disciplines should be made available. The Performing Arts Medicine Association would be the logical group to spearhead this effort.

Of equal importance is communicating information about performing arts medicine to the performers themselves and to their instructors at all levels. Particularly critical is the need to inform those who teach the very young, where the seeds of future playing-related problems are almost certainly germinated. We should encourage teachers to incorporate physiologic principles into the techniques used in playing, singing, or dancing. What can also be taught is how to approach learning a performing art, such as techniques of practicing, the importance of variation during practice sessions, avoiding the endless repetition of a series of movements, and the usefulness of mental preparation and learning away from the instrument or the dance floor. We can also make a contribution at the level of a conservatory or school. Instruction in the physical limitations of the musculoskeletal system, how to recognize the warning signs of impending physical or emotional problems, and principles of conditioning could all be incorporated into the curriculum.

There is a need to interest far more basic and clinical scientists in the unsolved problems of performing arts medicine. The mechanisms of development and the best methods of treating the muscle pain syndromes and occupational cramps that afflict performers are but two of the many urgent areas awaiting elucidation by the application of rigorous investigative methods. The technology exists to answer those important questions.

Coming of age generally requires the assumption of additional responsibility. Performing arts medicine is a field that has evolved out of the perceived need for specialized care for musicians, dancers, and other performers. We must solidify its foundations by expanding the knowledge base of information on the cause and treatment of performance-related disorders. We need to interest young physicians in the field and to develop programs to train them in its many aspects. Most important, we have to communicate what we have learned to the performing artists and their teachers to ensure that all who wish to avail themselves of these services can do so.

RICHARD J. LEDERMAN, MD, PhD
Department of Neurology
Medical Center for Performing Artists
Cleveland Clinic Foundation
Cleveland, Ohio

REFERENCES

1. Lockwood AH: Medical problems of musicians. N Engl J Med 1989; 320:221-227
2. Lederman RJ: Performing arts medicine (Editorial). N Engl J Med 1989; 320:246-248
3. Ostwald PF, Baron BC, Byl NM, Wilson FR: Performing arts medicine. West J Med 1994; 160:48-52
4. James IM, Parry CBW: Performing arts medicine. Br J Rheumatol 1992; 31:795-796
5. Sataloff RT, Brandfonbrener AG, Lederman RJ (Eds): Textbook of Performing Arts Medicine. New York, NY, Raven Press, 1991

Private *and* Social Insurance—The Feasible Option

THE RECENTLY RELEASED Clinton Health Plan (September 1993) drives home a number of thought-provoking insights regarding the future financing of long-term care. It also provides a critique of the feasibility of a universal social insurance program such as that proposed by Estes and Bodenheimer in this issue of the journal.[1]

The first lesson to be obtained from the proposed health plan is that a social insurance approach to long-term care is expensive. Of the $83 billion a year the Clinton Health Plan proposes for new public spending (once the program is fully operational), approximately $25 billion is devoted to a social insurance for long-term care, and that initial annual expenditure of $25 billion (based on full funding) provides only a dollar-limited amount of home- and community-based care for the most severely impaired persons.

Part of the reason even a limited social insurance program is so expensive is that a substantial portion of the total expenditures go to persons who can afford to insure themselves.[2] But even the incremental costs can be large and unpredictable in light of the high probability of induced demand. This is why the Clinton Plan had to include a "capped entitlement."

Ball captured the importance of these cost arguments: "The main policy and political problem, however, is putting the very large total costs on the government. The social insurance plan has to raise enough money to meet the total costs, not just the incremental costs, and it would have to do this in the face of many other important social needs."[3(p159)]